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Field/Category	**Instructions**
Annual Certification Due	This due date will be a minimum of 365 days from the date of this assessment. This is calculated from the assessment date and not from the date the physician signs the PCS PACT form.
Referral Date	Date provider received the initial referral for services. This date stays the same on all future PACT forms until the patient is discharged. If the patient is later reopened for services, the new referral date is entered on the new PACT form.
Date Initial Assessment Completed	Date provider completed the initial assessment in the patient's home. This date remains the same on all future PACT forms until the patient is discharged. If the patient is later reopened for services, a new assessment date is entered on the new PACT form.
Date Last Reassessment Completed	Date provider completed the last reassessment – this date may be the date of the last annual reassessment or the date a reassessment was completed due to a change in the patient's condition that required completion of a new PCS PACT form.
Provider Name	Name of provider agency at this licensed/enrolled site
PCS Provider #	PCS provider # assigned by DMA for this specific licensed/enrolled site
Provider Phone #	Provider agency phone number for this licensed/enrolled site including area code
Provider Address	Provider agency address for this specific licensed/enrolled site – include city, state and zip code
Field 1	Patient's first and last name as it appears on their Medicaid card (blue or pink)
Field 2	Medicaid ID # as it appears on their Medicaid card (blue or pink)
Field 3	Patient's Social Security Number
Field 4	Patient's address – include city, state, and zip code
Field 5	Patient's phone number – include area code
Field 6	Sex of the patient – male or female
Field 7	Patient's date of birth – month/day/year
Field 8	Indicates whom patient lives with – check all that apply
Field 9	Contact person's name – relationship to patient, address, phone no. at home and work – include zip code
Field 10	Attending physician's name – this is the name that must also appear as the authorizer of PCS Services on the PACT form, phone no. and address. This is the patient's primary physician. If the Medicaid card indicates Carolina ACCESS/Community Care the primary physician must be the Carolina ACCESS/Community Care physician.
Field 11	Date of most recent exam, month/day/year by primary physician.
Field 12	Vital signs taken by RN at assessment today

Field 13	Reason for referral for PCS services
Field 14	Diagnosis – specify date of onset and ICD-9 code (s) for the diagnosis/diagnoses related to the medical condition (s) supporting the need for PCS. Remember, the date of onset is critical in all surgical/orthopedic diagnoses. If the date is not known, you may give your best estimate of the date. For example, less than 5 years, etc.
Field 15	Current care – type and source – list informal and formal caregivers, example, Meals on Wheels, home health, etc.
Field 16	List all medications – name/dose/frequency/route – remember to include prescribed and over the counter medications, include oxygen flow rate and route.
Field 17	Indicate if medications are self-administered and who assists if applicable by name and relationship. Indicate if reminders are needed.
Field 18	Indicate if allergies and if yes, write in all known allergies – include food, medications and environmental allergies
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Patient First and Last Name	As it appears on the Medicaid card and page 1 of the PCS PACT Form
Medicaid ID	As it appears on the Medicaid card and page 1 of the PCS PACT Form
Assessment Date	Date this assessment is completed in the patient's home

Limitations in Activities of Daily Living (ADLs)

Rate the individual's ADL Self-Performance and ADL Support Provided using the scoring system provided. Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task.

M= Mon, T=Tues, W=Wed, Th=Thurs, F=Fri, S=Sat, Sun=Sunday

Completion of the assessment areas in each ADL field/category also includes completing scoring for column A. *ADL Self-Performance* and column B. *ADL Support Provided.* The last column provides a space for the assessor to check if PCS assistance is needed based on the assessment and scoring of columns A. and B. Be careful that the fields/category numbers where you have indicated assistance is needed match up to the category numbers on the POC.

The ADL Self Performance Scores are defined on the PCS PACT tool and more information on this scoring is available in the MDS scoring research.

0 Independent: No help needed or oversight needed
1 Supervision: Oversight, encouragement, or cueing needed
2 Limited Assistance: Individual highly involved in activity, receives hands-on help in guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and/or other non-weight bearing assistance.
3 Extensive Assistance: While individual performs part of activity, substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and/or weight bearing assistance is needed.
4 Full Dependence: Full performance of activity by another

The ADL score is tabulated by giving consideration to all boxes in each category. For example, if you scored in field 26 (personal hygiene) that the patient needed help with combing hair only, this would relate to the patient only needing limited assistance with a score of 2.

The ADL Support Provided Scores are also defined on the PCS PACT tool

0 No set-up or physical help needed
1 Set-up help only
2 One person physical assist
3 Two+ persons assist and/or one person assist w/ assistive equipment

Note - Home management tasks in each category are not included in your overall scoring of that category - only ADLS are scored. Home management tasks are linked to the patient's ADL deficits and functional health needs.

ADL Self-Performance Scores	Lists Scores 0-4, which corresponds with the patient's level of independence and/or dependence. The provider will place the applicable score – a 0, 1, 2, 3 or 4 - under column A - by each of the fields/categories 19-30 on the PCS PACT form.
ADL Support Provided Scores	Lists scores 0-3 which corresponds with the type of support the recipient needs with the task(s). The provider will place the applicable score - a 0, 1, 2, or 3 - under column B - by each of fields/categories 19-30 on the PCS PACT form.
Field 19	Ambulation – note assistive equipment patient is to use while ambulating or if patient is bed/chair bound – check all that apply. If bed or chair bound see field 20 for further instructions.

Field 20	Non-ambulatory/transfer – Moving to and between surfaces; bed, chair, wheelchair, standing position. Indicate assistive equipment patient is to use during transfer – check all that apply. Note self sufficiency once transferred.
Field 21	Nutrition – Check off whether the patient is fed orally, parenterally or by tube. Indicate in the blank by tube what type of tube the patient has. Check off whether patient is fed or set-up only. Write in the dietary restrictions. Write in any supplements the patient may be using. Write in the diet ordered. Check off whether meal prep is one meal or two meals and the days meals are to be prepared. Indicate what type of kitchen clean-up assistance is needed by circling all that apply. Use the blank line to write in the days of the week assistance is needed with kitchen clean-up.
Field 22	Respiration – place a check mark in the box by the patient's respiratory status – check all that apply. Place a check mark in the applicable box to indicate the patient's frequency of oxygen use and whether or not the patient utilizes a nebulizer. If the patient utilizes a nebulizer, write in the blank the days of the week assistance is needed through PCS. Then write in the blanks by any of the home management tasks the days of the week the task(s) is to be performed by PCS.
Field 23	Endurance – place a check mark in the applicable box indicating the patient's breathing status for how the patient appears most of the time. Then place a check mark in the box indicating whether or not the patient has generalized weakness. Then write in the blank(s) by any of the home management tasks the days of the week the task(s) is to be performed by PCS.
Field 24	Skin – place a check mark in the box indicating the patient's skin status. Check all that apply. Then indicate whether or not the patient needs help with A. *diabetic skin care* and/or B. *nail care* and the frequency that assistance is needed by writing in the blank(s) the days of the week PCS assistance is needed.
Field 25	Bathing – indicate by writing in the days of the week by A, B, or C the type of bathing assistance the patient needs through PCS and on what day the assistance is needed. Write in the day(s) of the week the patient needs help with D. *shampooing* and E. *clean bathroom after bathing*. Check off whether or not the patient needs help with *transferring in and out of the tub or shower* and/or the devices the patient needs. Remember the ADL self-performance score indicates the client's ability to self perform the identified task.
Field 26	Personal Hygiene – place a check mark in the boxes indicating if the patient needs assistance with a personal hygiene task. Then write in the blank(s) the days of the week assistance is needed with braiding or setting hair and/or shaving.

Field 27	Dressing - place a check mark in the boxes indicating if the patient needs assistance with dressing, etc. Then write in the blank(s) the days of the week assistance is needed with ROM and/or laundry.
Field 28	Bladder – Indicate the patient's urinary status and method by placing a check mark in the applicable boxes. Check off the frequency of assistance needed. Check off the devices/supplies needed.
Field 29	Bowel - Indicate the patient's bowel status and method by placing a check mark in the applicable boxes. Check off the frequency of assistance needed. Check off the devices/supplies needed. Write in the days of the week the patient needs an enema and/or assistance with a bowel program.
Field 30	Self-monitoring of pre-poured meds/blood sugars. The RN should identify for the aide the parameters to report. Complete all applicable boxes. If vital sign monitoring, self-monitoring and/or weights are identified as needed, the nurse should indicate the frequency of the task on the Plan of Care and parameters to report.
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Field 31	Pain – 7-day look back – indicate the location of the pain and severity of the pain using a rating scale of 0-10 with 0 being no pain and 10 being worst pain. Then indicate with a check mark the pain frequency and pain control. Remember – PCS PLUS pain criteria indicates the patient has consistent and substantial pain which interferes with daily activities.
Field 32	Cognitive Skills for Daily Decision Making – Check the box that describes the patient most of the time. If client is MR/DD note level or score. For example, mild; moderate; severe. This assessment is reviewed considering the patient's chronological age.
Field 33	Behavior – Check all that apply
Field 34	Vision – Check off the patient vision status and indicate if the patient uses glasses or contacts
Field 35	Check off the patient's hearing status and indicate if the patient uses a hearing aid
Field 36	Check off the patient's speech status. Note the primary language the patient speaks.
Field 37	Check off the patient's method of communication and indicate if the patient is unable to write. If so, the client must make a mark on this form and it be followed by the nurse assessor's initials. This is only required if the patient will be making a mark on the in-home aide service log. (If telephony or electronic time verification is used – refer to these criteria in policy.)

Field 38	Document additional time needed when deviating from time guidance. Document here information specific to patient needs for the other covered home management tasks that are not specifically linked to ADLs – such as reporting to DSS, writing letters, reading correspondence, etc. and also document EXCEPTIONS to identified time guidance.
Field 39	Write in the patient's perception of what he or she needs
Field 40	Indicate if the patient has other medical considerations by checking off all that apply
Field 41	Indicate if the patient has an advanced directive and if so the location of the document
Field 42	Indicate if there is a DNR order and complete all that apply – remember that Hospice recipients are not eligible for in-home PCS.
Field 43	Safety Assessment – Complete all that apply – also note DME supplier and contact information. Patient choice is to be upheld as related to DME. Remember - if the home is not adequate or suitable to complete the plan of care, the primary physician and/or other applicable resources should be notified. Do not open to PCS services.
Field 44	Indicate if there are any other sources as listed available to meet the patient's needs at the times the services have been requested. If so, PCS is not indicated.
Nurse Assessor/Certification – Signature of the RN completing the assessment and documentation on the PCS PACT form indicating whether or not the PCS services are needed. Your signature indicates that you completed this assessment and it accurately reflects the patient's condition and needs. Print your name legibly as it will be used to verify that you have completed the certification training. Record the time in and out of the home.	
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Assessment Date	Date this assessment is completed in the patient's home
Field 45	Plan of Care – If the assessment indicates that the patient has medically-related personal care needs requiring PCS, show the plan for providing the care beside the day(s) services are needed. Write in the category # of the assigned task(s) that is designated on the assessment and by the category # indicate the amount of time to be allocated to that specific task. Follow the DMA time guidance for time allotments. The category numbers on the POC should match up with the field/categories on the assessment that indicated that the patient needed assistance. Remember tasks and time allotted should be individualized. Remember – the tasks are based on the medical conditions and needs identified in the assessment. The time allotted is based on the time guidance and any documented exceptions.

	DMA expects an economy of tasks when there are multiple recipients in the same home. DMA expects staff to multi-task – for example – the aide may be preparing a meal while he/she is washing the clothes. Remember – many tasks are not required daily - such as mopping, laundry etc. Home management tasks should not exceed the time allotted for personal care. Remember – the patient can have no more than 3½ hours per day and no more than 60 hours per month. If PCS PLUS is requested and prior approved – the patient can have no more than 80 hours per month.
Field 46	Goals/Objectives: Complete all
Field 47	Verbal order – indicate if a verbal order was obtained to assess the patient and determine eligibility for PCS per the Medicaid Guidelines and indicate the date. If a written order was received, for example on a physician's prescription pad, incorporate this written order into the clinical record.
Field 48	Specify the date of the verbal order to start PCS and who conveyed the verbal order and who received the verbal order. This means you would document who in the physician's office, for example, conveyed the verbal order and then the nurse's name in your agency who took the verbal order. This follows NC BON interpretative guides.
Physician Certification	The patient's primary physician, PA or NP must sign and date prior to PCS services beginning unless a verbal order to begin services was obtained. If the physician failed to date his signature, the agency may stamp or note the date received in the agency. This is to note the date received only. Stamp or write in Rec'd and then the date. The agency cannot predate the form for the physician.